Some Legislation Issues of Interest, CHIPRA and Health Care Reform

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CHIPRA Enrollment and Outreach Grants

- Two Native American tribes in Nevada were recently awarded enrollment grants
- Covering Kids and Families applied for the grant on behalf of Nevada
- Medicaid could not guarantee State funding for additional enrollees
  - Cap and/or termination of program explored in budget cuts

CHIPRA Performance Bonus Payment

- Nevada must meet 5 out of the following 8 conditions in both CHIP and Medicaid to qualify for the performance bonus. The criteria must have been operational by April 1, 2009 to qualify for the first bonus.
- Nevada currently meets 2 out of the 8 conditions for both programs. There are two areas where one program meets the condition but the other does not.

CHIPRA Performance Bonus Payment

- Continuous eligibility – CHIP meets this condition; however, Medicaid did not receive legislative support due to the fiscal impact.
- Elimination of Asset test – CHIP and Medicaid meet this condition.
- Elimination of in-person interview – CHIP and Medicaid meet this condition.
- Use of Joint Application for Medicaid and CHIP – SB4 (Access Nevada) is the only process in the works and it is estimated that it will cost at minimum $150,000 to meet this condition.

CHIPRA Performance Bonus Payment

- Automatic Renewal – Requires pre-printed forms which would necessitate major NOMADS system changes. Although not researched, the fiscal impact to the current Medicaid caseload could make this option cost prohibitive.
- Presumptive Eligibility – This option has been proposed at the last several legislative sessions. It has not been supported due to the large fiscal impact.
- Express Lane – This would require contracts with identified Express Lane agencies that have the capability, funding and staff. Cost estimates have not been done but will cause a large fiscal impact.
- Premium Assistance Subsidies – CMS determined that the CHIP ESI program does not meet these conditions. This would require the development of a new program and any necessary funding.

Health Care Reform (HCR)

HCR interpretations and any implementation regulations and requirements have not yet been confirmed by Centers for Medicare and Medicaid Services (CMS). DHCFP currently has several policy and implementation questions posed to CMS on these and other Health Care Reform issues.

Health Care Reform
Health Homes (Section 2703)

- **Health Home Legislation**
  - Health home: one central provider is responsible for coordinating patient's care
  - Goals: improve health outcomes and reduce expenditures
  - For Medicaid enrollees with chronic conditions
    - 2 chronic conditions;
    - 1 chronic condition and is at risk of having a second chronic condition; or,
    - 1 serious and persistent mental health condition
  - 90% FMAP for two years
  - Funds will be available January, 2011
  - Planning grants also available January, 2011

Health Homes Activities to Date

- Researched best practices (if you have seen one medical home program, then you have seen one medical home program – all are different)
- Participated in local and national medical home coalitions
  - Patient Centered Primary Care Collaborative
  - Nevada Health Care Coalition
- Met or will be meeting with community partners, including:
  - UNR School of Medicine
  - FQHCs
  - HERE/Culinary Union
  - Access to Health Care Network

Health Homes Activities to Date

- Released Request for Information (RFI)
  - 9 responses
  - Supported research findings:
    - Need provider and community involvement throughout planning and implementation process
    - Assistance in creating and/or updating HIT systems needed for providers
    - Need to focus on long-term savings

Health Homes Current Activities and Next Steps

- Get answers from CMS on program and FMAP details
- Continue to meet with community partners
- Work with Medicaid EMR Incentive program to develop HIT component of health homes
- Submit planning grant to CMS (end of the year)

Health Care Reform
Community First Choice Option (Section 2401)

- Attendant Care Services in State Plan under 1915 (k) option
- May include expenditures for transition costs from an institution and for items that substitute for human assistance
- Would have a 6% increase in FMAP
- Must be Medicaid eligible (but can be offered to a person who is eligible under a category with and FPL up to 150% or 300% SSI if meets institutional level of care (persons on HCBS waiver programs).

Health Care Reform
Removal of Barriers to Providing Home and Community Based Services (Section 2402)

- Regulatory changes to ensure service systems are responsive, provide support for self direction, and improve provider coordination.

- Expansion of services that can be provided under 1915(i) to more closely align with services that can be provided under 1915(c) Home and Community Based Waivers.

- Allows for expansion of eligibility based on income and optional new Medicaid eligibility group specific to 1915(i).

- Provides waiver of comparability, ability to target services, no enrollment caps, and no waiver of statewideness.

Health Care Reform
Changes to Money Follows the Person Grants (Section 2403)

- Extends the end date for grants from 2011 to 2016,
- Reduces the period of time for institutional residence from six months to 90 days,
- Allows states that currently spend less than 50% of LTC services on non-institutional care to receive additional federal match.

Health Care Reform
Expand Aging and Disability Resource Centers (Section 2405)

- Expands funding for each of FFY 2010 – 2014 (total amount $10M each year).